
UNIT 3 ASSESSMENT IN CLINICAL PSYCHOLOGY

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3.0 INTRODUCTION

In this unit we will be discussing about assessment in clinical psychology. We start with definition and purpose of clinical assessment followed by psychological assessment as done by clinical psychologists. Then we take up the detection of certain disorders by clinical psychologists almost like that of detectives. Then we deal with the comprehensive psychological assessments that clinical

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psychologists make. Then we deal with types of psychological assessment which includes under it addiction assessments, description of the addiction and mental illness test called FAMHA (Functional Assessment of Mental Health and Addiction Scale). Then we deal with typical characteristics of MISU (Mentally II substance users), SUMI (Substance Using Mentally Ill) and MCSU (Medically compromised substance using patents) characteristics. Then we present how then scale FAMHA was developed and its reliability and validity. The next section deals with the referral and how clinical psychologists deal with the same in terms of assessment. This is followed by assessment in clinical psychology within which we dealm with how assessment helps in deciding on therapy, planning therapy, conducting therapy and evaluating therapy.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe the psychological assessment in clinical setting;
- Explain the different types of psychological assessment;
- Explain the purpose of clinical assessment;
- Explain the referral and assessment;
- Describe assessment in clinical psychology; and
- Describe the applications of psychological assessment in the field of clinical psychology.

3.2 DEFINITION AND PURPOSE OF CLINICAL ASSESSMENT

Psychological assessment as an area of emphasis has seen its ups and downs. Abeles (1990) commented on the recent “rediscovery” of assessment. He observed that during the 1960s and 1970s, there seemed to be a decline in interest in psychological assessment. Therapy was the more glamorous enterprise, and assessment almost seemed somehow “unfair” to clients. It appeared that clinical psychology’s historical commitment to assessment was waning. The prevailing attitude about assessment was “Let the technicians do it!” But in the 1980s, something else began to happen. Students began to show an interest in specialisation. They discovered forensic psychology (the application of psychology to legal issues), or they became intrigued by pediatric psychology, geriatrics, or even neuropsychology.

But to become a specialist in such areas, one needs to know a great deal about assessment. You cannot answer a lawyer’s questions about the competence of a defendant unless you have thoroughly assessed that individual through tests, interviews, or observations. You cannot decide on issues of neurological insult versus mental disorder until you have assessed that client. As Abeles (1990) stated:

“It is my contention that one of the unique contributions of the clinical psychologist is the ability to provide assessment data. Providing assessments is again becoming a highly valued and respected part of clinical psychology and in my opinion is

coequal with intervention and psychotherapy as a vital activity of clinical psychology. Let us continue to rediscover assessment! (p. 4).

3.2.1 Definition of Psychological Assessment

Psychological assessment can be formally defined in many ways. Clinical assessment involves an evaluation of an individual's strengths and weaknesses, a conceptualisation of the problem at hand (as well as possible etiological factors), and some prescription for alleviating the problem; all of these lead us to a better understanding of the client. Assessment is not something that is done once and then is forever finished. In many cases, it is an ongoing process—even an everyday process, as in psychotherapy. Whether the clinician is making decisions or solving problems, clinical assessment is the means to the end.

Intuitively, we all understand the purpose of diagnosis or assessment. Before physicians can prescribe a treatment, they must first understand the nature of the illness. Before plumbers can begin soldering pipes, they must first determine the character and location of the difficulty. What is true in medicine and plumbing is equally true in clinical psychology. Aside from a few cases involving pure luck, our capacity to solve clinical problems is directly related to our skill in defining them. Most of us can remember our parents' stern admonition: "Think before you act!" In a sense, this is the essence of the assessment or diagnostic process.

3.2.2 Psychological Assessments

Physicians run "tests" to identify illnesses or diseases. Sometimes one test identifies the source of problems such as an x-ray revealing a tumor, or a blood test showing low iron levels or anemia. However, some illnesses aren't so clear-cut, requiring a battery of tests and medical procedures to accurately diagnose complex conditions.

Clinical psychologist's tools also are used to diagnose learning disabilities, determine competency to stand trial for a crime, and guide individuals into a deeper understanding of their vocational and avocational likes and dislikes.

Clinical psychologists similarly use various tools, called psychological tests to help diagnose mental illness and disease. But like complex medical conditions, tests often don't provide all the answers, so psychologists rely on a broader educational tool called an "assessment" to more accurately diagnose psychological conditions. Based on assessments, psychologists develop and apply effective therapeutic treatment plans and interventions

3.2.3 Psychologists as Detectives

Psychologists conducting assessments are like detectives trying to solve a case. The assessment requires a gathering of information from multiple sources, from written tests, personal interviews, job history records, and reports and records from other physicians, therapists, and counselors. The clinical psychologist compiles an entire "case history" or in-depth story of a person's inner and outer life, a sort of journey into the intricacies of psyche and behaviours. Past and present life situations are also considered.

According to Wikipedia, 91% of clinical psychologists perform some type of assessment. But the complexity of the assessment depends on several factors, such as the clinical setting, the severity of the condition, and the age and ability

of the particular client. For example, an assessment done on a child struggling in school will be quite different from an assessment conducted with a suspected criminal. And an assessment given to a soldier in Afghanistan experiencing symptoms of trauma will differ dramatically from an individual seeking treatment for depression from a psychotherapist who uses a form of “talk therapy” to diagnose and treat clients.

A “full” assessment of the soldier probably isn’t likely given the conditions of war and fighting, yet military psychologists are trained to assess soldiers using other methods, such as observational or interview-type approaches, to determine an effective immediate intervention, or to determine if the soldier needs to be removed from the situation and admitted to a military facility for a more thorough assessment, and longer term therapy. Likewise, psychotherapists in private settings have more flexibility in the type of assessment given to clients than psychotherapists working in a mental health facility or hospital, which often recommends standard, commonly used tools for tests and assessments.

3.2.4 Comprehensive Assessments

The strength of the psychological assessment process stems from its comprehensive, scientific methodology. Testing implies something like a blood test, where you just give a test and get a number,” explained Smith, also in private practice and a faculty member at the University of California, Berkeley. “Assessment is a much more complex enterprise where you integrate data points from various places to get a more comprehensive understanding. Psychologists must be able to select the best assessment tools available for certain client populations, and to become, in a sense, wise consumers of psychological research. Also, a post-assessment must occur after a psychological intervention has been applied, assessing the impact on the client’s behaviour and progress toward healing.

3.2.5 Psychological Assessment as Important Tools

Scientific research in clinical psychotherapy has evolved since its beginnings after World War II, as psychologists attempted to understand and treat soldiers with shell shock – what today is called post traumatic stress disorder. Over the years, many in the scientific community have questioned the reliability and validity of psychological testing as compared to medical testing. studies conducted over the past few decades have proven the efficacy of psychological tests, according to professionals working in the field. In the American Psychological Association’s journal “Monitor,” an article by Jennifer Draw explored the results from a study conducted by the American Psychological Association’s Psychological Assessment Work Group. The PAWG researchers found that many psychological tests produce results of comparable validity to medical tests such as Pap smears, mammography, magnetic resonance imaging (MRI) and electrocardiograms. As an example, the researchers cited test scores from the Minnesota Multiphasic Personality Inventory (MMPI) that had an average ability to detect depressive or psychotic disorders with the same reliability that Pap tests detect cervical abnormalities.

The researchers also went a step further to conclude that some psychological tests work as well as medical tests in detecting the same illnesses. They point to neuropsychological testing for dementia producing results with the same level of effectiveness as an MRI.

3.2.6 Reliability and Validity

Reliability means that an experiment or test reports the same results after a repeated number of trials. Independent researchers must be able to replicate experiments using the same controls as the original researchers, making the research generalisable. Validity determines if the experiment measures exactly what the researchers attempted to measure – or the specific concept under study. External validity means that the study results are generalisable; internal validity concerns the rigor of the study's design and procedures.

Self Assessment Questions

- 1) Define clinical assessment.

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- 2) Describe the purpose of assessment.

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- 3) What are psychological assessments?

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- 4) Describe psychologists as detectives.

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- 5) Discuss psychological instruments as important tools.

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3.3 TYPES OF PSYCHOLOGICAL ASSESSMENT

Thousands of psychological tests exist all falling in one of the following categories:

- i) intelligence or IQ tests, such as WAIS IV , WICS IV, Stanford Binet,
- ii) Cattell Culture Fair III,
- iii) Woodcock Johnson Tests of Cognitive Abilities III.

- iv) Attitude scales such as Thurstone scale or Likert scale and
- v) Personality tests such as the MMPI, MCMI III,
- vi) Beck Depression Inventory and
- vii) Child Behaviour Check List.
- viii) The Rorschach Test used less frequently is also a personality test.
- ix) Direct Observation tests, such as the Parent-Child Interaction Assessment-II, the MacArthur Story Stem Battery and the Dyadic Parent-child Interaction Coding System.

3.3.1 Addiction Assessments

The assessment of client functioning is a critical component of both treatment outcome evaluation and assessment of individual level of need for individual treatment planning and service delivery selection. This is especially true for the dually diagnosed client with multiple concomitant needs, on a variety of levels.. The Functional Assessment of Mental Health and Addiction scale (FAMHA) was specifically designed to meet both criteria.

While it is beneficial to note the positive client changes that occur due to the effects of treatment, it is perhaps more important to have a functional baseline or clinical yardstick with which to plan an effective strategies of biopsychosocial interventions. This is of utmost importance for dually diagnosed clients, with multiple service needs in mental health, addiction treatment, and medical interventions.

A basic, core goal of all treatment is to produce substantial and enduring changes in client behaviours, cognitions and moods and more useful strategies for managing their day-to-day lives. The only other goal of treatment is then to reduce a client's distress to the greatest degree possible. By determining a client's specific level of functioning across all major biopsychosocial domains and an overall level of functioning, specific symptom and functional deficit profiles emerge that can then be used for more effective treatment planning. Such assessments are client centered by their very nature and specifically relate to the distress and difficulties that each patient must endure in their daily lives. Thus, functional assessments like the FAMHA are the key to not only measuring the outcomes of treatments on a broad scale, but crucial to the clinician's full understanding of patient's individual needs.

3.3.2 Description of the FAMHA

The Functional Assessment of Mental Health and Addiction (FAMHA; Anderson & Bellfield, 1999) is a clinician rating scale, specifically designed to accurately assess dually diagnosed, across a broad range of symptom and functional domains. It was developed in response to clinical and outcome research goals identified by the Department of Health (1996) which emphasised the need for extending research on the outcome of treatment for substance misuse problems. It is meant for three different types of addicts.

- i) mentally ill substance users (MISU),
- ii) substance using mentally ill (SUMI), and
- iii) medically compromised substance using patients (MCSU)

The assessment scale is specifically tailored to assess the multifaceted needs of severely distressed patients and to identify specific areas for effective therapeutic interventions. The 46 items of the scale document functional deficits across all biopsychosocial functional domains in such a way as to capture the current state of overall functioning, whilst demonstrating specific areas of need.

Thus, it can be used as both an indicator of current functioning for diagnostic assessment and as a repeated measure to demonstrate the changes that occur to patients throughout the clinical cycle.

Sciacca (1991) noted significant differences between various subpopulations of dually diagnosed patients (in both mental health and addiction treatment settings) that have an impact on treatment planning and service delivery for each patient population. The term dual diagnosis is somewhat broad and misleading (for example; mental illness and learning disabilities are dual diagnoses).

The distinction between MISU, SUMI, and MCSU patients has a significant impact on the selection and use of a variety of intervention techniques and strategies.

MISU patients generally present with symptoms of severe and enduring mental illness that has been complicated by the use of psychotropic substances.

SUMI patients are characterised by their excessive use of psychotropic agents with the subsequent development of a concomitant severe and persistent mental illness.

MCSU patients characteristically use large amounts of psychotropic agents in the presence of a long term or severe physical injury, illness or ongoing medical condition.

Traditionally, MISU patients have gravitated toward mental health treatment systems, SUMI patients have generally sought treatment in addiction treatment settings; while MCSU patients have relied on medical treatment facilities to seek therapeutic relief.

Mental illness, substance use/misuse and medical conditions must be approached differently for each group to achieve effective therapeutic outcomes (Sciacca, 1991). The severe and persistent mental illness of MISU patients make it difficult for them to engage in the motivational interviewing or more restrictive treatments often used in addiction treatment settings (Bachrach, 1984).

On the other hand, SUMI and MCSU patients often require relief from the effects of addiction and withdrawal before they can fully focus on their treatment for the medical, psychological and social issues that have emerged or intensified as a result of their substance use.

For this reason, the FAMHA was designed to assess individual differences in symptomatology, whilst differentiating these two populations on a functional level.

Effective treatment of MISU, SUMI and MCSU patients requires diagnostic clarification as the initial step in successful care planning. To address the problem of multiple diagnoses of mental illness, medical conditions and substance abuse, clinicians from addiction, medical, and psychiatric backgrounds must learn to make the clinical formulations for each of the concomitant disorders, using clear diagnostic standards and evidence based assessments.

One of the principal goals of the FAMHA is to quantitatively measure the degree and intensity of mental illness and substance misuse. It also profiles the interactive effects of multiple disorders that must be explored on an individual basis.

The consideration of which disorder came first, while perhaps etiologically important, should not interfere with the diagnosis and treatment of persistent conditions that exist and simultaneously interact on a functional level (Breakey, 1987; Miller, 1994).

A major advantage of using the FAMHA is that it can be quickly and effectively administered to provide diagnostic indicators and monitor the effects of treatment over time.

The following list identifies many of the characteristics that distinguish MISU, SUMI and MCSU patients which can be quantitatively assessed on the FAMHA:

3.3.3 MISU Characteristics

- 1) Severe mental illness exists independently of substance abuse; persons would meet the diagnostic criteria of a major mental illness even if there were not a substance abuse problem present.
- 2) MISU persons have a DSM-IV-R, Axis I (American Psychiatric Association, 1987) diagnosis of a major psychiatric disorder, such as schizophrenia or major affective disorder.
- 3) MISU persons usually require medication to control their psychiatric illness; if medication is stopped, specific symptoms are likely to emerge or worsen.
- 4) Substance abuse may exacerbate acute psychiatric symptoms, but these symptoms generally persist beyond the withdrawal of the precipitating substance.
- 5) MISU persons, even when in remission, frequently display the residual effects of major psychiatric disorders (for example, schizophrenia), such as marked social isolation or withdrawal, blunted or inappropriate affect, and marked lack of initiative, interest, or energy.

Evidence of these residual effects often differentiates MISU from populations of substance abusers who are not severely mentally ill.

3.3.4 SUMI Characteristics

- 1) SUMI patients have severe substance dependence (alcoholism; heroin, cocaine, amphetamine, or other addictions), and frequently have multiple substance abuse and/or polysubstance abuse or addiction.
- 2) SUMI persons usually require treatment in alcohol or drug treatment programs. SUMI persons often have coexistent personality or character disorders.
- 3) SUMI patients may appear in the mental health system due to "toxic" or "substance-induced" acute psychotic symptoms that resemble the acute symptoms of a major psychiatric disorder. In this instance, the acute symptoms are always precipitated by substance abuse, and the patient does not have a primary Axis I major psychiatric disorder.
- 4) SUMI patients' acute symptoms remit completely after a period of abstinence or detoxification. This period is usually a few days or weeks, but occasionally may require months.

- 5) SUMI patients do not exhibit the residual effects of a major mental illness when acute symptoms are in remission.

3.3.5 MCSU Characteristics

- 1) MCSU patients continued to use large amounts of substances even after their medical conditions have gone into remission or have been successfully treated.
- 2) These patients begin using psychotropic agents in an effort to seek relief from physical pain due a medical condition.
- 3) MCSU patients often have long term medical conditions (i.e. HIV, Heart Conditions, Autoimmune deficiencies, etc.) that reduces their level of physical functioning and makes them vulnerable to substance use disorder.
- 4) The hopeless and helpless feelings associated with long term or severe medical conditions produce depressive states that are reduced by the use of intoxicating or pain relieving substances.
- 5) The loss of physical function and range of motion often produces a reduction in psychological functioning and increases the reliance on pharmacological agents.

3.3.6 Development of the Scale

The FAMHA was developed with a variety of criteria in mind. To adequately assess MISU, SUMI, and MCSU patients in naturalistic settings, specific criteria developed by Green and Greely (1987) were applied to the scale as it was modified in development phases and pilot trials. It was felt that the FAMHA should not only assess the obvious symptom categories of major mental illness and addiction, but should also:

- include functional domains that are deemed important for community based treatment clinics;
- demonstrate reliability and validity;
- possess sensitivity to treatment-related change;
- be appropriate and relevant to the dually diagnosed population that it functionally assesses;
- be a useful tool for treatment planning and clinical governance;
- have low administration costs;
- be relatively easy to use by all levels of clinical staff.

The current version of the FAMHA meets all of these criteria and can be administered in as little as 8 minutes by a trained, experienced rater.

The FAMHA builds on the strengths of the Specific Level of Functioning scale (SLOF) (Schnieder & Struening - 1983), Symptom Checklist 90 (SCL-90R)(Derogatis, 1975), the Bellevue Psychiatric Audit (BPA)(Hardesty & Burdock, 1962) and the Addiction Severity Index, 5th Edition (ASI)(McLellan et al, 1997). It combines a variety of clinical and functional dimensions into a 46 item clinician rating scale that is subdivided into 6 biopsychosocial dimensions:

- 1) Socio-legal
- 2) Social – Community Living
- 3) Social – Interpersonal Skills
- 4) Mood
- 5) Psychological Functioning
- 6) Physical Functioning.

In addition to the dimensional scales, data as to the patient's primary and secondary drug of choice, alcohol consumption, prior mental health and addiction treatment episodes, demographics, and current medical, mental health and addiction diagnoses are also collected to add to the clarity of the diagnostic profile. It is expected that continued statistical analysis, including factor analyses of further trials, will yield more refined, discrete scale dimensions and add to the overall utility of the instrument.

Similar to the SLOF in appearance, the FAMHA uses a seven point, three way anchored Likert like scale, ranging from extremely dysfunctional symptoms or behaviours (Score 1) to normative levels of these behaviours and symptoms (Score 7).

The low end, mid-point and high points of functioning are anchored by descriptors for each item. This allows for enhanced inter rater reliability and validity of patient/ clinic-wide functional assessments.

Like the SLOF and SCL-90R, each of the 46 items of the FAMHA is evaluated on the Likert-like scale. Due to the specific nature of each of these 46 functional items, the FAMHA assumes a high degree of assessor familiarity with the patient.

The scale was designed to quantify patient functional levels more systematically than the Global Assessment of Functioning (GAF)(APA, 1994) and provides for the systematic rating of functional deficits in critical areas of that could not otherwise be assessed in this population. In addition, FAMHA overall scores are designed with a coefficient that readily converts the total score to overall GAF scores. Thus, it refines the diagnostic profile for individual patients that is necessary for appropriate diagnosis within both ICD-10 (WHO-1996) and DSM-IV (APA 1994) diagnostic systems.

3.3.7 Validity and Reliability

The concordance rates between the FAMHA total scores, sub-scores and GAF scores are currently in clinical trials and cannot yet be reported on. However, due to the high degree of similarity between the SLOF and the FAMHA, it is assumed that patient scores on each FAMHA dimension will significantly correlate with overall GAF scores and subscores.

The SLOF concordance rates for the various components were reported to be $r = .67$ for the social component, $.60$ for the psychological, and $.50$ for the physical component. Moderate associations were found between the SLOF substance abuse scale and the Drake et al. (1990) substance abuse scale ($r = .73$) (Uehara et al. 1994).

This concordance rate should be mirrored in the FAMHA, since most of these specific SLOF items are embedded in the FAMHA as well.

Further clinical trials should conclusively demonstrate the usefulness of combining level of functioning information across mental health and addiction dimensions and ultimately, validate the FAMHA as an ideal instrument for assessing dually diagnosed patients in mental health and addiction treatment settings.

To sum up this section, the FAMHA documents the outcomes of treatment by quantifying the substantial and enduring changes in client behaviours, cognitions, moods and day-to-day client functioning. It also notes reductions in distress due to the effects of treatment. By determining a client's specific level of functioning across a number of domains and an overall level of functioning, specific profile emerge that can then be used for more effective treatment planning.

FAMHA assessments are client centered by their very nature and specifically relate to the distress and difficulties that each patient must endure in their daily lives. Thus, such assessments are crucial to a client's mental health, substance use, and medical recovery.

The FAMHA was designed to meet the specific clinical and research needs of practitioners/researchers in a wide variety of treatment settings. From the data currently available, it is clear that the FAMHA is a sensitive diagnostic tool for use with MISU, SUMI and MCSU patients. Its ability to document functional changes that occur throughout the treatment cycle and utility as a basic research tool to obtain specific epidemiological and diagnostic information make it an ideal instrument for use with on this severely dysfunctional and distressed population.

Self Assessment Questions

- 1) What are the various types of psychological assessments?

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- 2) Describe FAMHA.

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- 3) Describe the characteristics of MISU, SUMI and MCSU.

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4) How was the FAMHA scale developed?

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5) Discuss the reliability and validity of the scale.

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3.4 THE REFERRAL

The assessment process begins with a referral. Someone—a parent, a teacher, a psychiatrist, a judge, or perhaps a psychologist—poses a question about the patient. “Why is John disobedient?”

“Why can’t Anita learn to read like the other children?” “Is the patient’s impoverished behavioural repertoire a function of poor learning opportunities, or does this constriction represent an effort to avoid close relationships with other people who might be threatening?”

Clinicians thus begin with the referral question. It is important that they take pains to understand precisely what the question is or what the referral source is seeking. In some instances, the question may be impossible to answer; in others, the clinician may decide that a direct answer is inappropriate or that the question needs rephrasing. For example, the clinician may decide that the question “Is this patient capable of murder?” is unanswerable unless there is more information about the situation. Thus, the question might be rephrased to include probabilities with respect to certain kinds of situations. If parents want their child tested for the sole, often narcissistic, purpose of determining the child’s IQ, the clinician might decide that providing such information would eventually do the child more harm than good. Most parents do not have the psychometric background to understand what an IQ estimate means and are quite likely to misinterpret it. Thus, before accepting the referral in an instance of this kind, the clinical psychologist would be well advised to discuss matters with the parents.

3.4.1 Factors that Influence Clinician Response to Referral Question

The kinds of information sought are often heavily influenced by the clinician’s theoretical commitments. For example, a psychodynamic clinician may be more likely to ask about early childhood experiences than a behavioural clinician. In other cases, the information obtained may be similar, but clinicians will make different inferences from it. For example, frequent headaches may suggest the presence of underlying hostility to a psychodynamic clinician but merely evidence of job stress to a behavioural clinician. For some clinicians, case-history data are important because they aid in helping the client develop an anxiety hierarchy; for

others, they are a way of confirming hypotheses about the client's needs and expectations.

Assessment, then, is not a completely standardised set of procedures. All clients are not given the same tests or asked the same questions. The purpose of assessment is not to discover the "true psychic essence" of the client but to describe that client in a way that is useful to the referral source—a way that will lead to the solution of a problem. Of course, this does not mean that one description is as good as another for a particular case. One clinician's cognitive-behavioural formulation of a case may involve a poor understanding of cognitive-behavioural theory. There are even instances in which certain cases seem to lend themselves more to a psychodynamic description than to a behavioural description. Because of the complexity of our subject matter and incomplete state of our knowledge, there is sometimes more than one good road to Rome.

3.5 ASSESSMENT IN CLINICAL PSYCHOLOGY

Psychological assessment is utilised in clinical psychology primarily for purposes of differential diagnosis, treatment planning, and outcome evaluation.

Differential diagnosis involves drawing on assessment information to describe an individual's psychological characteristics and adaptive strengths and weaknesses. These descriptions provide a basis for determining

What type of disorder an individual may have,

The severity and chronicity of this disorder and the circumstances in which it is likely to be manifest, and

The kinds of treatment that are likely to provide the individual relief from this disorder.

With respect to further treatment planning, adequate assessment information helps to guide treatment strategies and anticipate possible obstacles to progress in therapy. As for outcome evaluation, pre-treatment assessments establish an objective baseline against which treatment progress can be monitored in subsequent evaluations, and by which the eventual benefits of the treatment can be judged at its conclusion. These clinical contributions of psychological assessment can be implemented during each of four sequential phases in delivering psychological treatment: deciding on therapy, planning therapy, conducting therapy, and evaluating therapy.

3.5.1 Deciding On Therapy

The first step in the clinical utilisation of assessment information consists of deciding whether a patient needs treatment and is likely to benefit from it. Accurate differential diagnosis identifies pathological conditions (e.g. depression, paranoia) and maladaptive characteristics (e.g. passivity, low self-esteem) for which treatment is usually indicated, and adequate psychological evaluation helps to distinguish such conditions and characteristics from normal range functioning that does not call for professional mental health intervention. Assessment methods also provide valuable information concerning two factors known to predict whether people are likely to become involved in and profit from psychotherapy: their motivation for treatment and their accessibility to being treated.

Motivation for treatment usually corresponds to the amount of subjectively felt distress that people are experiencing. Accessibility to psychological treatment typically depends on how willing people are to examine themselves, to express their thoughts and feelings openly, and to make changes in their customary beliefs and preferred ways of conducting their lives. Information derived from appropriate assessment procedures can provide clinicians with objective indices of each of these variables, and these assessment data can in turn be used as a basis for determining whether to recommend and proceed with some form of treatment.

3.5.2 Planning Therapy

- Planning therapy for patients who need and want to receive psychological treatment involves .
- Deciding on the appropriate setting in which to deliver the treatment,
- Estimating the duration of the treatment, and
- Selecting the particular type of treatment to be given.

With respect to deciding on the treatment setting, assessment data provide reliable information concerning the severity of a patient's disturbance, the patient's ability to distinguish reality from fantasy, and his or her likelihood of becoming suicidal or dangerous to others, all of which bear on whether the person requires residential care or can be treated safely and adequately as an outpatient. The more severely disturbed people are, the farther out of touch with reality they are, and the greater their risk potential for violence, the more advisable it becomes to care for them in a protected environment.

Regarding treatment duration, clinical experience and research findings consistently indicate that mild and acute problems of recent onset can usually be treated successfully in a shorter period of time than severe and chronic problems of long-standing duration. A variety of psychodiagnostic measures provide clues to the chronicity as well as the severity of symptomatic and characterological mental and emotional problems, and pretreatment data obtained with these measures can accordingly help clinicians formulate some expectation of how long a treatment is likely to last. Having available such assessment-based information on expected duration in turn assists clinicians in presenting treatment recommendations to prospective patients (Hurt, Reznikoff & Clarkin, 1991).

As for treatment selection, people who are relatively psychologically minded, self-aware, and interested in gaining fuller self-understanding are relatively likely to respond positively to an uncovering, insight-oriented, and conflict focused treatment approach. Patients whose preference is to feel better without having to examine themselves closely, on the other hand, are more likely to become actively engaged in supportive and symptom-focused approaches to treatment than in exploratory psychotherapy.

Psychologically minded people are inclined to feel dissatisfied with supportive treatment, because it does not get at the root of their problems, whereas relief-minded people tend to feel uncomfortable in uncovering treatment, because it makes unwelcome demands on them.

Additionally, there is reason to believe that some kinds of conditions and difficulties, especially in people who are problem-oriented, respond relatively well to cognitive-behavioural forms of treatment, whereas other kinds of disorders and maladaptive

tendencies, especially in people who are interpersonally oriented, respond better to psychodynamic-interpersonal than cognitive behavioural therapy (Beutler & Harwood, 1995; Hayes, Nelson & Jarrett, 1987).

Psychological mindedness and preferences for problem-oriented or interpersonally oriented approaches to life situations are among a vast array of personality characteristics that can be measured with assessment methods. Accordingly, adequately conceived pre-therapy psychological assessment can facilitate treatment planning by differentiating among psychological states and orientations of the individual that have known implications for successful response to particular treatment approaches.

3.5.3 Conducting Therapy

Psychological assessment can play a key role in conducting therapy by helping to identify in advance:

- Treatment targets on which the therapy should be focused and
- Possible obstacles to progress towards these treatment goals.

Appropriately collected assessment data, and particularly the results of a multimethod test battery, typically contain many normal range findings and often some indications as well of notably good personality strengths and especially admirable personal qualities. At the same time, especially in people who are being evaluated for symptoms or difficulties that have led them to seek professional help, test data are likely to reveal specific adaptive shortcomings and coping limitations. One person may show a penchant for circumstantial reasoning and poor judgement; another person may give evidence of poor social skills and interpersonal withdrawal; a third may exhibit considerable emotional inhibition with restricted capacity to express feelings and feel comfortable in emotionally charged situations.

In short, any assessment findings that fall outside of an established normal range and are known to indicate specific types of cognitive dysfunction, affective distress, coping deficit, personal dissatisfaction, or interpersonal inadequacy in turn assist therapists and their patients in deciding on the objectives of their work together and directing their efforts accordingly.

Some psychological characteristics of patients that constitute targets in their treatment may also pose obstacles to their becoming effectively engaged in therapy and making progress toward their goals. For example, people who are set in their ways and characteristically rigid and inflexible in their views often have difficulty reframing their perspectives or modifying their behaviour in response even to well-conceived and appropriately implemented treatment interventions. People who are interpersonally aversive or withdrawn may be slow or reluctant to form the kind of working alliance with their therapist that facilitates progress in most forms of therapy.

People who are relatively satisfied with themselves and not experiencing much subjectively felt distress may have little tolerance for the demands of becoming seriously engaged in a course of psychological treatment. Characteristics of these kinds do not preclude effective psychotherapy, but they can result in slow progress, and they may cause patients and therapists to become discouraged and terminate prematurely a treatment that does not appear to be going well.

Pretreatment assessment data serve to alert therapists in advance to possible treatment obstacles, which can help them understand and be patient with initially slow progress and also guide them in dealing directly with these obstacles, as by concentrating in the early phases of therapy on encouraging flexibility and open-mindedness, building a comfortable and trusting treatment relationship, or generating some motivation for the patient's involvement in the therapy.

3.5.4 Evaluating Therapy

Psychological assessment provides valuable data for monitoring the progress of therapy and measuring its eventual benefit. For this potential benefit of assessment to be realised, it is vital for assessment data to be collected from patients prior to their beginning treatment. In addition to helping to identify treatment targets and the long term objectives of therapy, pre-treatment data provide an objective baseline for comparison with the results of subsequent assessments.

Periodic reevaluations can then shed light on whether the treatment is making a difference, how close it has come to meeting its aims, in what way the focus of continued treatment should be adjusted, and whether a termination point has been reached. For example, if a reliable test index shows abnormally high anxiety, low self-esteem, poor self-control, or excessive anger, and a retest during treatment shows the same or a worse result for any of these treatment targets, there is objective evidence that no progress has been made on this front. Such results can then lead to an informed decision to alter the type or focus of the treatment, change the therapist, or await the next re-assessment before making any change.

On the other hand, should retesting show an index closer to an adaptive range than initially, there is reason to conclude that progress is being made on the treatment target related to that index but that further improvement remains to be made in that area. When an initially abnormal test result is found on retesting to be in an adaptive range, then therapists and their patients can conclude with confidence that they have achieved the objective to which this result relates and do not need to address it further. At the point when retesting indicates that most or all of the treatment targets have reached or are approaching as much resolution as could realistically be expected, then the assessment process helps to indicate that an appropriate termination point has been reached.

Assessments conducted at the conclusion of psychotherapy, when compared with initial baseline evaluations, provide an objective basis for evaluating the overall benefit of the treatment that has been provided. Evaluations of treatment benefit made possible by pre-therapy and post-therapy assessments serve important research and practical purposes in clinical psychology. With respect to research issues, assessment data bearing on treatment benefit facilitates comparison studies of the relative effectiveness of different types and modalities of therapy. For practical purposes, retest findings demonstrating treatment benefit bear witness to the value of psychological interventions, particularly as weighed against the financial cost of these services (Kubiszyn et al., 2000).

3.6 INSTRUMENTS

Surveys of clinical psychologists and the contents of standard handbooks concerning psychological assessment identify several instruments as being among those most widely used by clinicians in the United States for purposes of differential diagnosis,

treatment planning, and outcome evaluation. Four of these measures are relatively structured self-report inventories on which conclusions are derived from what respondents are able and willing to say about themselves: the Minnesota Multiphasic Personality Inventory, the Millon Clinical Multiaxial Inventory, the Sixteen Personality Factors Questionnaire, and the Personality Assessment Inventory.

Four of them are relatively unstructured performance based measures in which the key data consist not of what respondents say about themselves but how they deal with various kinds of somewhat ambiguous tasks that are assigned to them: the Rorschach Inkblot Method, the Thematic Apperception Test, several types of figure drawing tasks, and some alternative sentence completion methods.

Self Assessment Questions

1) What is Referral and what does it involve?

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2) Discuss the assessment in clinical psychology.

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3) How is psychological assessment used in deciding therapy?

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4) How is psychological assessment used in planning therapy?

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5) Discuss psychological assessment for conducting and evaluating therapy.

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- 6) State some of the instruments of clinical psychology.

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3.7 LET US SUM UP

Psychological assessment has been an integral part of clinical psychology since its inception and continues to the present day to provide practitioners with valuable information to guide their evaluation and treatment of persons who seek their help. At times, failure to appreciate the benefits of preceding treatment with thorough assessment has led to insufficient teaching and learning of psychodiagnostic methods by clinical psychologists, as has the regrettable and shortsighted devaluing of diagnostic procedures by health insurance providers. However, the future application of psychodiagnostic methods in clinical psychology appears to rest safely in the hands of practitioners and researchers who know from their experience and data how useful assessment can be in facilitating good clinical decisions.

3.8 UNIT END QUESTIONS

- 1) What is the definition and purpose of clinical assessment?
- 2) Discuss in detail the application of psychological assessment in clinical psychology?
- 3) Write about some of the most widely used instruments in clinical assessment?
- 4) Describe the FAMHA, its devising, its use, and reliability and validity.
- 5) How is psychological assessment used in clinical settings?

3.9 SUGGESTED READINGS

Plante, T. G. (2005). *Contemporary Clinical Psychology (2nd Ed.)*. New Jersey: John Wiley & Sons, Inc.

Trull, T.J. (2005). *Clinical Psychology (7th Ed.)*. USA: Thomson Learning, Inc.